NEW JERSEY
DEPARTMENT OF AGRICULTURE

EQUINE NEUROLOGIC DISEASE WORKSHEET
General Information and History

Veterinarian:

Name: _____

Address: _____

_____

Phone: _____ *Fax:* _____

Owner of Animal:

Name: _____

Address: _____

_____

Phone: _____ *Fax:* _____

Trainer of Animal *(if applicable):*

Name: _____

Address: _____

_____

Phone: _____ *Fax:* _____

Location of Animal:

Name: _____

Address: _____

_____

Phone: _____ *Fax:* _____

Is the animal: *Alive*❑ *Dead*❑ *Euthanized*❑ *Date/time of death:*_____

Signalment:

Stallion❑ *Gelding*❑ *Mare*❑

If mare, is she pregnant? *Yes*❑ *No*❑

Name: _____

Tattoo #: _____

Age: _____

Breed: _____

Color: _____

*Use (racing, breeding, etc.):*_____

Vaccination History:

(check box if yes) ***Date of last vaccination?***

❑EEE/WEE _____

❑Tetanus _____

❑Rabies _____

❑EPM _____

❑Lyme _____

❑Rhino _____

Date/time of onset of illness:

_____

Date/time of initial veterinary examination:

_____

Other animals on farm? *Yes*❑ *No*❑

Species: _____

_____

Number on farm:_____ ***Number sick:*** _____

Travel History: *(list travel history for the past 30 days—if more space needed, check box* ❑ *and continue on back of form)*

Date(s) traveled from farm:	***Traveled to (****city,state):*	***Duration of trip:***	***Reason for trip*** *(racing, show, trail ride, etc.)*

New Jersey Department of Agriculture
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Initial Clinical Information

Owner name: _____ ***Animal name:***_____

Does the animal have any possible bite wounds? *yes*❑ *no*❑

Have humans been bitten or exposed to saliva? *yes*❑ *no*❑
If yes, how many people were exposed? _____ *(list names and phone numbers on back of form)*

Is the animal isolated from other animals? *yes*❑ *no*❑

Has a local health department been notified? *yes*❑ *no*❑ *if yes, which one?* _____

Signs: *(check box if observed or described)*

❑ ataxia *(circle one)*	❑ agitation	❑ muscle fasciculation	❑ hypersensitivity	❑ aggression
front rear quad	❑ disorientation	❑ excessive sweating	❑ hypermetria	❑ vocalization
❑ hindlimb weakness	❑ inability to rise	❑ anorexia	❑ teeth grinding	❑ stargazing
❑ apprehension	❑ almost falling	❑ eating hay	❑ excess salivation	❑ seizures
❑ depression	❑ rise w/assistance	❑ eating grain	❑ circling	❑ other (describe below)

_____

_____

Body temperature:	***Date/time taken:***
_____	_____
_____	_____
_____	_____

Treatments: *(list medications)*	***Dosage, route, duration of treatment?***
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Laboratory specimens collected:	***Date:***	***Lab to which specimens sent:***
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other info: _____